Robert R. Goldwin, D.D.S.
744 E. Brookhaven Circle
Memphis, TN 38117

FINANCIAL AGREEMENT
AND
INITIAL DISCLOSURE NOTICE

The undersigned Patient or Responsible Party agrees that the following terms will govern the payment of professional services rendered by the Doctor and charged to his account:

1. Patient agrees to pay the New Balance of his account in full within 25 days of the billing date, as indicated on the monthly billing statement.

2. There will be a $25.00 charge for returned checks.

3. Patient authorizes Doctor to obtain any and all information necessary to obtain credit information from third parties for patients treatment.

4. Doctor may refuse to render future treatment until the amount outstanding has been paid in full.

5. Patient is responsible for all costs of collection including, but not limited to, reasonable attorney fees, and a minimum amount of 33 1/3% of the amount sought, if this amount is turned to an attorney for collection.

6. There will be a charge for broken appointments unless 24 hours notice is given.

The Undersigned Patient or Responsible Party acknowledges that he has read the information printed above.

Patient or responsible party: _____

Date: _____